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MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

41268

Registration District No.

Primary Registration District No.

Registrar's No.

10391

1. PLACE OF DEATH:

(a) County St. Louis Mo.
 (b) City or town St. Louis Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
7053 Cleatka
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
 (Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME

Infant Stella Powers

8. (b) If veteran, name war _____

8. (c) Social Security No. _____

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: Dec (Month) 4 (Day) 1939 (Year)8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 30 min.9. Birthplace St. Louis Mo. (City, town, or county) (State or foreign country)10. Usual occupation Fulltime

11. Industry or business _____

12. Name James Powers13. Birthplace Paris Mo. (City, town, or county) (State or foreign country)14. Maiden name Myrtle M. Kenna15. Birthplace Newburg Mo. (City, town, or county) (State or foreign country)16. (a) Informant's own signature James Powers(b) Address 7053 Cleatka17. (a) Removal (b) Date thereof 12-4-39 (Month) (Day) (Year)(c) Place: burial or cremation Newburg Mo.18. (a) Signature of funeral director Albert W. Hopper(b) Address 4700 Washington Av.19. (a) DEC 5 1939 (b) J. J. B. [Signature]

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 1
 (c) City or town St. Louis 3
 (If outside city or town limits, write "RURAL")
 (d) Street No. 7053 Cleatka Av.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December 4 day year 1939 hour 10 minute 30 A. M.21. I hereby certify that I attended the deceased from 12-4-39 19____ to 12-4-39 19____that I last saw him alive on same Dec 4 1939 and that death occurred on the date and hour stated above.

Immediate cause of death _____

Patent foramen ovale full term

Due to _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy no

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

_____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature P. B. Cappel (M. D. or other)Address 3539 [Address] Date signed 12-4-39

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

10391

10391

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.